Office of Statewide Health Planning and Development - Extension Request

Hospital Annual Disclosure Report

Health Facility Name (D.B.A.):			**Date:**
OSHPD Facility No:	**Report Period Ending**		**Check One:** ___Initial ___Additional
Street Address:	**City:**	**State:**	**Zip Code**:
Mailing Address: (If Different)	**City:**	**State:**	**Zip Code**:

Number of Days Requested
(60 days initial request, 30 days 2nd request - with a maximum of 90 days allowed):

Reason(s) Which Prevent(s) Completion by Deadline (Justification for Extension):

Actions Needed to Complete Report Within The Extended Time:

I hereby certify that I am authorized to request this extension:

Requestor's Name:	**Signature:**	**Phone No:**

Mailing Address:	**City**	**State**	**Zip Code**:

Mail to: Office of Statewide Health Planning & Development
Accounting & Reporting Systems Section, Attn: Patricia Burritt
400 R street, Room 400 , Sacramento, CA 95811-6213

or **FAX to: (916) 323-7675**
or E-Mail as an attachment to **pburritt@oshpd.ca.gov**

If you have questions call: Patricia Burritt at (916) 326-3855